STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145257	A. BUILDING _____ B. WING _____	08/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL PINES REHAB & HCC	**335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey. An extended survey was conducted.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to identify medical symptoms to justify the use of a self-releasing waist restraint, did not provide alternatives to restraint use, did not follow the individualized restraint Care Plan, and failed to implement restraint reductions, for one of four residents sampled with restraints, (R7), in a sample of 21. Additionally, the facility failed to follow their Restraint Policies and Procedures. Findings include: The revised 9-2000 Restraint Use Policy and Procedure is, "Policy: It is the policy of the facility to utilize restraints only when necessary to treat the resident's medical symptoms. The facility will use the least restrictive device necessary to treat that medical symptom and not for the purpose of discipline or convenience. Procedure: The following steps must be completed prior to and during the continued use of a restraint. 1.	F 221		9/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 221	Continued From page 1 Complete a pre-restraining assessment, indicating the medical symptoms requiring the restraint. 3. Initiate an appropriate treatment plan to include: How the use would treat the medical symptom. How it will assist the resident in attaining or maintaining his/her highest practical well-being. Addressing the potential for negative outcomes, which might be specific to the individual resident. A plan for reduction to the use of an alternative, and/or less restrictive device. Referrals to assist in the reduction and use of the least restrictive device. 4. Attempt to minimize or eliminate the medical symptom, to address any underlying problems causing the medical symptom. 5. Ongoing assessment for the continued need of a restraint. The facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request, demand, or approval." R7's Admission Nursing Note of 7-10-2000 is, "(R7) has a, (Brand Name self-releasing waist restraint), in place due to impaired decision making skills." The 3-3-2011 Quarterly and 5-25-2011 Annual MDS, (Minimum Data Set) contain documentation that R7 is assessed to have short and long term memory deficits, is severely impaired in daily decision making and does not exhibit behavioral symptoms. R7 is also assessed to be totally dependent on staff members for all activities of daily living. These same MDS assessments contain documentation that R7 has not had any falls since re-admission to the facility on 5-1-2005. R7's June 1, 2011 through 8-31-2011 monthly	F 221		

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F 221	Continued From page 2 Physician Orders are, "(A self-releasing waist restraint) on while (R7's) up in wheelchair for safety." The 5-30-2011 Individualized Care Plan, for R7, contains the following documentation, "Restraint use: Full siderails for safety per family request. (A self-releasing waist restraint) due to lack of safety awareness, per family request." Interventions identified include, "Check restraint for restrictions every thirty minutes." On 8-15-2011 from 1:05pm. to 2:15pm. R7 was in her wheelchair with a self-releasing waist restraint on. Staff did not reposition, toilet, or check on R7 for this same time period. Quarterly Contracture Assessments from 7-1-2010 through 3-2-2011 contain documentation that R7 is "High Risk" for contractures. The 7-3-2010 through 8-18-2011 Quarterly Scale for Predicting Pressure Sore Risk contain documentation that R7 is "High Risk" for pressure ulcers. Quarterly Resident Fall Risk Assessments of 7-3-2010 through 5-25-2011 document R7 is "Moderate Risk" for falls. Safety Device Documentation of 7-27-2010 at 2:00pm. is, "(R7) has been supplied with a (A self-releasing waist restraint) and siderails, up x 2, for safety, due to low cognition and inability to understand her limitations.....(R7) is dependant for all activities of daily living, incontinent of bowel and bladder, with severe cognitive impairment.	F 221		

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F 221	Continued From page 3 (R7) is unable to follow commands and cannot self-release. (Z3, Family Member/Power of Attorney), has discussed her concerns for (R7's) safety and wishes (R7) to have both, (A self-releasing waist restraint), and siderails x2, at this time. The facility has discussed this with (Z3), and are supportive of her wishes to maintain (R7's) safety. 3-25-2010, at this time (Z3) does not feel a reduction would be beneficial to her, due to her medical conditions, cerebral vascular accident, alzheimer's disease, and dementia." The 2-28-2011, 4-18-2011, and 5-25-2011 Physical Restraint Elimination Assessments contain documentation that R7's "Medical Symptoms Necessitating Use of Restraint: impaired cognition." The 2-28-2011 and 4-18-2011 Reduction or Elimination are, "while in bed." A 5-25-2011 Reduction or Elimination of restraint interventions/plan, etc. are not identified. Alternatives for continued attempts for restraint reduction documented for 2-28-2011, 4-18-2011, and 5-25-2011 are toileting, activities, and call light prompts. On 8-15-2011 at 11:05am., 8-15-2011 at 1:30pm. and 8-16-2011 at 9:20am. R7 was unable to release the lap restraint, after being asked to do so. E5, (ADON/Assistant Director of Nursing) on 8-16-2011 at 11:47am. stated, "(R7) cannot release the (A self-releasing waist restraint). We are releasing (R7's) lap restraint every two hours and at lunch, for reduction of restraint. I will check on what else we are doing to reduce (R7's) restraint use." E5 provided no further information.	F 221		

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F 221	Continued From page 4 On 8-17-2011 at 10:55am. E2, (DON/Director of Nursing) stated, "There is nothing further on restraint reduction for (R7). The family is adamant about the restraint. (R7) came here with the restraint, and the doctor, (Z2), is very pro-family and resident requests. We have contacted the doctor, (Z2) about this. It comes up every year."	F 221		
F 224 SS=H	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed/neglected to follow and implement the facility's policy and procedure for "Pressure Ulcer Prevention" in the following areas; 1. Assessment; - A standardized pressure ulcer risk assessment (Braden Scale) will be used to identify residents who are at risk for the development of pressure ulcers. This assessment will be completed upon admission, weekly x 4 weeks, quarterly and when a significant change in the resident's condition is noted. 2. Planning: - An individual plan of prevention will be developed to meet the needs of the resident. It will include the consideration of mechanical support surfaces, nutrition, hydration, positioning,	F 224		9/20/11

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mobility, continence, skin condition and overall clinical condition of the resident as well as the risk factors as they apply to each individual.
3. Implementation: - Interventions for the prevention of pressure ulcers will be individualized to meet the specific needs of the resident. Interventions will consider the assessment of risk and skin condition of the resident.
4. Evaluation and Reassessment: - The facility's Care Management System committee will review program components to evaluate the effectiveness of the prevention program and facility systems. Findings and recommendations will be reviewed with the QA Clinical Committee. Based on evaluation, the need for reassessment and further changes to the individual resident' plan of care will be determined and acted upon.

This is for 5 (R4, R5, R6, R8, R14) of the 7 residents sampled for pressure sores in a total sample of 21 with 3 residents (R24, R25 and R26) in the supplemental sample.

These failures contributed to the development and worsening of avoidable facility acquired pressure sores in various stages for these 8 residents.

Findings include;

A review of the facility's "Resident Census and Conditions of Residents" under section "D" Skin Integrity noted that the facility reported 13 residents with pressure sores and only 2 of these residents had pressure sores on admission.

In an interview on 8/16/11 at 2:30 PM with E1, the

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F 224	Continued From page 6 administrator and E2, the director of nursing, they stated that they are aware of the problem regarding pressure sores recently acquired in the facility. E1 stated that they are looking at the reasons why this occurred. E1 stated that in July 2011 the facility census went from 90 to over 100 and that the facility had to hire more staff to meet the needs of their residents. E1 stated that the care was not given as it should be regarding pressure sore prevention because they did not have enough staff. On 8/17/11 at 10:15 AM E1 stated that after looking at the staffing, they now believe that staffing was sufficient. E1 stated that the facility experienced power outages that utilized the back-up generator. E1 stated that the primary goal during these power outages was making sure the residents were hydrated. E1 stated that perhaps some preventive care was overlooked at this time. In an interview on 8/22/11 at 9:30 AM with Z1, the medical director, he states that he was aware of the facilities acquired pressure sores in the quarterly quality assurance meetings. Z1 states that he was probably informed of the increasing numbers of acquired pressures sore but he does not recall how many the facility has. Z1 states that he believes in the general philosophy of pressure sore prevention that includes skin checks, frequent repositioning and incontinence care. Z1 states that the facility needs to be vigilant in these preventive measures. Z1 states that there was a breakdown in these processes but he cannot say where the breakdown occurred. Z1 states that he was not involved in recommending interventions but that he did agree with the plan of removal regarding the immediate jeopardy situation.	F 224		

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F 224	Continued From page 7 1. On 8/16/11 at 10:10 AM R5 was in bed waiting for her dressing change. E6, the wound care nurse, removed R5 ' s coccyx dressing. R5 ' s wound is a Stage 3 pressure ulcer measuring 2.1 centimeter (cm) by 1.3cm by .2cm depth. The pressure sore has a thin center yellow slough approximately 25%. These measurements confirms a worsening of the pressure sore. The record of R5, a 78 year old female admitted to the facility on 8/15/09 with diagnoses (co morbidities) including Diabetes, Coronary Artery Disease, Hypertension and Anxiety was reviewed. R5 ' s record contains a physician ' s treatment order dated 7/18/11 that states. " Cleanse coccyx with sterile normal saline apply Maxorb AG and a 4 by 4 Exuderm every 3 days and as needed until resolved. " R5 ' s record contains a " Braden " pressure sore scale dated 6/13/11 that states she scored a 15 which is considered " mild risk " The minimum data set dated 5/17/11 states that she needs extensive assistance to transfer, assistance to position herself in bed, and uses a wheelchair for ambulation and is incontinent of bowel and bladder. R5's "Weekly Pressure Ulcer Assessment" sheet dated 7/18/11 that states this is the date that a stage 2 coccyx pressure sore was identified and measured .52 cm by .51cm. R5's "Weekly Pressure Ulcer Assessment" dated 7/26/11 states that the wound is now 1.5cm by 1.5cm by .1 depth which is a worsening of the pressure sore. R5's "Weekly Pressure Ulcer Assessment" sheet dated 8/2/11 states that her pressure sore is a stage 3 measuring 1.5cm by .8cm by .2cm with 50% necrotic tissue, this is a significant worsening of the pressure sore.	F 224		

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F 224	Continued From page 8 R5's "Weekly Pressure Ulcer Assessment" sheets show a decline or worsening in the pressure sore every week. The physician's order sheet do not show a change in treatment since the onset of the pressure sore on 7/18/11. R5's record lacks a comprehensive plan of care to prevent and treat pressure ulcers. In an interview with E6, the wound care nurse, she states that some physician's utilize a wound care clinic and some do not. E6 stated that some physician's are open to treatment suggestions and some are not. E6 stated she does not remember which residents have physician's that will use a wound clinic. E6 stated that she is aware that the wound is worse than it was previously. 2. On 8/16/11 at 10:20 AM R14 was in bed waiting for her heel dressing to be changed. R14 has an unstageable pressure ulcer to her left heel measuring 4.0cm by 5.0 cm by .1 cm at the periphery of the wound. R14's wound has a black eschar center (75%) with surrounding red tissue. This is a worsening of the "suspected deep tissue injury" that was documented on 8/9/11. The record of R14,an 87 year old female admitted to the facility on 6/20/11 with diagnoses (co morbilities) including Pelvic Fracture, Hypertension, Weakness and Difficulty in walking, was reviewed. R14's record contains a "Braden Scale for Predicting Pressure Sore Risk" dated 7/11/11 that states she scored a 22 which is "mild risk" on this scale. R14's record contains a "Weekly Pressure Ulcer Assessment' dated 8/5/11 that states a suspected deep tissue injury	F 224		

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F 224	Continued From page 9 was found and measured 5.2cm by 5.9cm and depth is stated as "blister". R14's record contains a physician's order for treatment dated 8/8/11 that states "Cleanse left medial heel with normal saline. Apply skin prep to intact blister, cover with optifoam and wrap with kerlix." R14's record contains a Minimum Data Set (MDS) dated 6/20/11 that states she needs assistance with bed mobility, transfers dressing and hygrine. R14's MDS states that she uses a wheelchair for ambulation and she continent of bowel and bladder. In an interview with E6,the wound care nurse, she stated that she does not know how this resident developed her pressure sore and that her assessments states she was at low risk for development of pressure sores. 3. On 8/16/11 at 10:00 AM E6 stated that R4 was admitted to the hospital last night due to her pressure sores. E2, the director of nursing, presented a history and physician report from the hospital regarding R4. This report states "...She is here from the nursing home with chief complaint of right foot pain and right foot drainage...Family also noted that the patient also had decubitus ulcers for some time but noted increased wound care needs for the past month...2 unstageable ulcers on the patient's right foot, foul smelling with necrotic tissue present. Also deep tissue injury in the medial right knee and decubitus on the right hip...Will be consulting surgery for wound debridement and care..." The record of R4's record contains an 84 year old female admitted to the facility in June of 2010 with diagnoses (co morbidity) including Diabetes,	F 224		

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Dementia, Anxiety Hypertension and Joint disease was reviewed. R4's MDS dated 5/26/11 states that she requires assistance with turning in bed, transferring, dressing and bathing. R4's MDS also states that she is frequently incontinent of both bowel and bladder and that she uses a wheelchair for ambulation. E4's record contains a "Braden scale for predicting pressure sore risk" dated 7/6/11 that states a score of 10 that signifies "high risk" for pressure sores. R4's record contains "Weekly Pressure Ulcer Assessment" dated 6/16/11 that states this date is when a stage 3 right hip pressure ulcer was identified and measured 3cm by 1.8cm by .2cm with 60% necrotic tissue. R4's record contains a "Weekly Pressure Ulcer Assessment" dated 8/6/11 that states a stage 2 left medial knee pressure ulcer was noted measuring 3cm by 2cm by .2cm depth. R4's record contains a "Weekly Pressure Ulcer " dated 8/9/11 that states the left medial knee pressure sore is now a stage 3 with 75% necrotic tissue.

4. On 8/16/11 at 11:00 AM R25 was in bed waiting for her dressing change. E6 measured the right buttock wound at .3cm by .2cm by .1 cm depth and a Stage 2 pressure ulcer. The wound was bleeding slightly.
E6 stated that she does not know why R25 developed this pressure ulcer.

The record of R25 a 94 year old female admitted to he facility with diagnoses (co morbidities) including Urinary Incontinence, Depression and Hypertension was reviewed. R25's record contains a "Braden Scale for Predicting Pressure Sores" that state she scored an 11 on 7/24/11 which is considered "High Risk" R25's record

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contains a "Weekly Pressure Ulcer Assessment" dated 8/2/11 that states she acquired a left buttocks stage 2 pressure ulcer measuring .5cm by .8cm by .1 cm depth. R25's record contains an MDS dated 7/21/11 that states she required extensive assistance to transfer and toilet and some assistance for bed mobility and dressing. This MDS states R25 used a wheelchair for ambulation and that she is incontinent of uri ne and occasionally incontinent of bowel.

5. On 8/16/11 at 10:30 AM R6 was in bed waiting for her dressing change. E6 measured her right hip Stage 2 pressure sore as .5cm by .5cm and her thoracic spine Stage 2 pressure sore as .8cm by .7cm by .1 cm depth. E6 states that she does not know why this resident developed her pressure sores.

The record of R6 a 93 year old female admitted tot he facility with diagnoses(co morbidities) including Congestive Heart Failure, Late Effect Cerebral Vascular Accident and Muscle Weakness was reviewed. R6's record contains a "Weekly Pressure Ulcer Assessment" dated 6/4/11 that states she acquired a thoracic spine Stage 2 pressure sore measuring .3cm by .3cm by .1cm. R6's record contains a "Weekly Pressure Ulcer Assessment" dated/12/11 that states she acquired a right hip pressure sore measuring 1.3cm by .2cm. R6's record contains an MDS dated 6/5/11 that states she required extensive assistance with transfers, dressing and hygiene. This MDS also states that she is incontinent of bowel and bladder.

6. On 8/16/11 at 11:50 AM R24 was in bed

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waiting for her dressing change. E6 measured her left buttock Stage 2 pressure sore 1cm by .5cm by .1 cm depth. This wound was bleeding slightly. E6 stated that she does not know why R24 developed a pressure ulcer.

The record of R24 an 88 year old female admitted to the facility with diagnoses (co morbidities) including Dysphagia, Atrial Fibrillation, Ischemic Heart Disease and Dementia was reviewed. R24's record contains a "Braden Scale for Predicting Pressure Sore Risk" dated 8/5/11 that scores her a 15 which is considered "Mild Risk". R24's record contains a "Weekly Pressure Ulcer Assessment" dated 8/5/11 that states her right inner buttock Stage 2 pressure ulcer measured 1.6cm by .6cm by .001 cm depth. R24;s record contains a MDS dated 7/5/11 that states she requires extensive assistance to transfer and for dressing. This MDS also states that R24 requires assistance with bed mobility, eating and hygiene and that she is frequently incontinent of urine and occasionally incontinent of bowel.

7. On 8/16/11 E6 stated that R26 refused to have another dressing change for observation purposes. On 8/18/11 E1, the administrator stated that R26 was being admitted to the hospital due to respiratory problems.

The record of R26 an 82 year old female admitted to the facility with diagnosis including Diabetes (co morbidities) was reviewed. R26's record contains a "Braden Scale for Predicting Pressure Sore Risk" dated 8/6/11 that scores her 15 which is considered "Mild Risk". R26's record contains a "Weekly Pressure Ulcer Assessment"

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F 224	Continued From page 13 dated 8/6/11 that states she developed a right inner buttock pressure sore measuring .8cm by 1 cm by .01 cm depth. R26's record contains an MDS dated 8/10/11 that states she requires extensive assistance for transfers, dressing and hygiene. This MDS also states that she requires assistance with bed mobility. This MDS also states that R26 is incontinent of bowel and bladder. 8. On 8/16/2011 at at 11:45 A.M., R8's skin condition was checked in the presence of E10 (CNA-certified nurse assistant). R8 has a stage II pressure ulcer on her right upper spine. Review of record "Monthly Skin Assessment" dated 8/8/2011 showed that R8's pressure ulcer measures 1.5 x 3x 0.1 cm. According to R8's record,this pressure ulcer was first identified and was acquired by R8 at the facility on 8/8/2011. Review of current care plan indicated that R8 was identified with at risk for pressure ulcers related to declining condition, incontinence of bladder and bowel, history of CVA(cerebral vascular accident), right sided weakness and loss sensation in feet. The care plan indicates that interventions to address R8's pressure ulcer includes for R8 to be placed on a pressure redistributing mattress in bed and wheelchair cushion. R8 was observed on 8/15/2011 at around 10:30 A.M., 8/16/2011 at 12:30 P.M., and 2:30 P.M. R8 was sitting in a reclining wheelchair. Further observation showed that R8 was sitting directly on the reclining wheelchair without a pressure redistribution chair cushion. On 8/16/2011 at 2:30	F 224		

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F 224	Continued From page 14 P.M., E13 (CNA) stated that she never had seen R8 's reclining wheelchair cushion. On 8/16/2011 at 3:10 P.M. during the daily status meeting, the concern that R8 was without redistribution cushion in a reclining wheelchair was discussed with E1 (Administrator) and E2 (Director of Nursing). On 8/17/2011 at 12:30 P.M., R8 was observed in the main dining room. R8 was sitting on a reclining chair. R8 was still without a pressure redistribution cushion. E5 (Assistant Director of Nursing) was present during this observation. All of the documentation presented by the facility was reviewed.	F 224		
F 314 SS=H	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to: 1. Implement a pressure ulcer intervention to prevent the development of facility acquired	F 314		9/20/11

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F 314	Continued From page 15 pressure ulcers for eight residents R4 and R14 with Un-stageable pressure sores, R5, R6 and R8 with Stage 3 pressure sores, R24 and R25 with Stage 2 pressure sores and R26 with a stage 1 pressure sore), and 2. Provide the necessary care and services to promote healing, and prevent developed pressure sores from worsening for three residents (R5 and R4). This is for 5 of the 7 residents sampled for pressure sores in a total sample of 21 with 3 residents in the supplemental sample. These failures contributed to the development and worsening of avoidable pressure sores in various stages for these eight residents. Findings include; 1. On 8/16/11 at 10:10 AM, R5 was in bed waiting for her dressing change. E6, the wound care nurse, removed R5 's coccyx dressing. R5 's wound is a Stage 3 pressure ulcer measuring 2.1 centimeter (cm) by 1.3cm by .2cm depth. The pressure sore has a thin center yellow slough approximately 25%. These measurements indicate a worsening of the pressure sore. The record of R5 noted a 78 year old female admitted to the facility with diagnoses (co morbidities) including Diabetes, Coronary Artery Disease, Hypertension and Anxiety. R5 's record contains a physician's treatment order dated 7/18/11 that states. " Cleanse coccyx with sterile normal saline apply Maxorb AG and a 4 by 4 Exuderm every 3 days and as needed until resolved. " R5's record contains a " Braden Pressure sore scale" dated 6/13/11 that states	F 314		

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F 314	Continued From page 16 she scored a 15 which is considered " mild risk " The minimum data set dated 5/17/11 states that she needs extensive assistance to transfer, assistance to position herself in bed, and uses a wheelchair for ambulation and is incontinent of bowel and bladder. R5's "Weekly Pressure Ulcer Assessment" sheet dated 7/18/11 noted that a Stage 2 coccyx pressure sore was identified and measured .52 cm by .51cm. R5's "Weekly Pressure Ulcer Assessment" dated 7/26/11 states that the wound is now 1.5cm by 1.5cm by .1 depth which is a worsening of the pressure sore. R5's "Weekly Pressure Ulcer Assessment" sheet dated 8/2/11 states that her pressure sore is a stage 3 measuring 1.5cm by .8cm by .2cm with 50% necrotic tissue, this is a significant worsening of the pressure sore. R5's "Weekly Pressure Ulcer Assessment" sheets show a decline or worsening in the pressure sore every week. The physician's order sheets do not show a change in treatment since the onset of the pressure sore on 7/18/11. R5's record lacks a comprehensive plan of care to prevent and treat pressure ulcers. In an interview with E6, the wound care nurse, she states that some physician's utilize a wound care clinic and some do not. E6 stated that some physician's are open to treatment suggestions and some are not. E6 stated she does not remember which residents have physician's that will use a wound clinic. E6 stated that she is aware that the wound is worse than it was previously. 2. On 8/16/11 at 10:20 AM R14 was in bed waiting for her heel dressing to be changed. R14 has an unstageable pressure ulcer to her left heel	F 314		

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F 314	Continued From page 17 measuring 4.0cm by 5.0 cm by .1 cm at the periphery of the wound. R14's wound has a black eschar center (75%) with surrounding red tissue. This is a worsening of the "suspected deep tissue injury" that was documented on 8/9/11. The record of R14,an 87 year old female admitted to the facility with diagnoses (co morbilities) including Pelvic Fracture, Hypertension, Weakness and Difficulty in walking, was reviewed. R14's record contains a "Braden Scale for Predicting Pressure Sore Risk" dated 7/11/11 that states she scored a 22 which is "mild risk" on this scale. R14's record contains a "Weekly Pressure Ulcer Assessment' dated 8/5/11 that states a suspected deep tissue injury was found and measured 5.2cm by 5.9cm and depth is stated as "blister". R14's record contains a physician's order for treatment dated 8/8/11 that states "Cleanse left medial heel with normal saline. Apply skin prep to intact blister, cover with optifoam and wrap with kerlix." R14's record contains a Minimum Data Set (MDS) dated 6/20/11 that states she needs assistance with bed mobility, transfers dressing and hygrine. R14's MDS states that she uses a wheelchair for ambulation and she continent of bowel and bladder. In an interview with E6,the wound care nurse, she stated that she does not know how this resident developed her pressure sore and that her assessments state she was at low risk for development of pressure sores. 3. On 8/16/11 at 10:00 AM E6 stated that R4 was admitted to the hospital last night due to her pressure sores. E2, the director of nursing, presented a history and physician report from the hospital regarding R4. This report states "...She	F 314		

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F 314	Continued From page 18 is here from the nursing home with chief complaint of right foot pain and right foot drainage...Family also noted that the patient also had decubitus ulcers for some time but noted increased wound care needs for the past month...2 unstageable ulcers on the patient's right foot, foul smelling with necrotic tissue present. Also deep tissue injury in the medial right knee and decubitus on the right hip...Will be consulting surgery for wound debridement and care..." The record of R4 an 84 year old female admitted to the facility with diagnoses (co morbidity) including Diabetes, Dementia, Anxiety, Hypertension and Joint disease was reviewed. R4's MDS dated 5/26/11 states that she requires assistance with turning in bed, transferring, dressing and bathing. R4's MDS also states that she is frequently incontinent of both bowel and bladder and that she uses a wheelchair for ambulation. E4's record contains a "Braden scale for predicting pressure sore risk" dated 7/6/11 that states a score of 10 that signifies "high risk" for pressure sores. R4's record contains "Weekly Pressure Ulcer Assessment" dated 6/16/11 that states this date is when a stage 3 right hip pressure ulcer was identified and measured 3cm by 1.8cm by .2cm with 60% necrotic tissue. R4's record contains a "Weekly Pressure Ulcer Assessment" dated 8/6/11 that states a Stage 2 left medial knee pressure ulcer measuring 3cm by 2cm by .2cm depth. R4's record contains a "Weekly Pressure Ulcer " dated 8/9/11 that states the left medial knee pressure sore is now a Stage 3 with 75% necrotic tissue. 4. On 8/16/11 at 11:00 AM R25 was in bed waiting for her dressing change. E6 measured	F 314		

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F 314	Continued From page 19	F 314		

the right buttock wound at .3cm by .2cm by .1 cm depth and a Stage 2 pressure ulcer. The wound was bleeding slightly.
E6 stated that she does not know why R25 developed this pressure ulcer.
The record of R25 a 94 year old female admitted to he facility with diagnoses (co morbidities) including Urinary Incontinence, Depression and Hypertension was reviewed. R25's record contains a "Braden Scale for Predicting Pressure Sores" that state she scored an 11 on 7/24/11 which is considered "High Risk" R25's record contains a "Weekly Pressure Ulcer Assessment" dated 8/2/11 that states she acquired a left buttocks stage 2 pressure ulcer measuring .5cm by .8cm by .1 cm depth. R25's record contains an MDS dated 7/21/11 that states she required extensive assistance to transfer and toilet and some assistance for bed mobility and dressing. This MDS states R25 used a wheelchair for ambulation and that she is incontinent of uri ne and occasionally incontinent of bowel.

5. On 8/16/11 at 10:30 AM R6 was in bed waiting for her dressing change. E6 measured her right hip Stage 2 pressure sore as .5cm by .5cm and her thoracic spine Stage 2 pressure sore as .8cm by .7cm by .1 cm depth. E6 states that she does not know why this resident developed her pressure sores.
The record of R6 a 93 year old female admitted to the facility with diagnoses(co morbidities) including Congestive Heart Failure, Late Effect Cerebral Vascular Accident and Muscle Weakness was reviewed. R6's record contains a "Weekly Pressure Ulcer Assessment" dated 6/4/11 that states she acquired a thoracic spine

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F 314	Continued From page 20 Stage 2 pressure sore measuring .3cm by .3cm by .1cm. R6's record contains a "Weekly Pressure Ulcer Assessment" dated/12/11 that states she acquired a right hip pressure sore measuring 1.3cm by .2cm. R6's record contains an MDS dated 6/5/11 that states she required extensive assistance with transfers, dressing and hygiene. This MDS also states that she is incontinent of bowel and bladder. 6. On 8/16/11 at 11:50 AM R24 was in bed waiting for her dressing change. E6 measured her left buttock Stage 2 pressure sore 1cm by .5cm by .1 cm depth. This wound was bleeding slightly. E6 stated that she does not know why R24 developed a pressure ulcer. The record of R24 an 88 year old female admitted to the facility with diagnoses (co morbidities) including Dysphagia, Atrial Fibrillation, Ischemic Heart Disease and Dementia was reviewed. R24's record contains a "Braden Scale for Predicting Pressure Sore Risk" dated 8/5/11 that scores her a 15 which is considered "Mild Risk". R24's record contains a "Weekly Pressure Ulcer Assessment" dated 8/5/11 that states her right inner buttock Stage 2 pressure ulcer measured 1.6cm by .6cm by .001 cm depth. R24;s record contains a MDS dated 7/5/11 that states she requires extensive assistance to transfer and for dressing. This MDS also states that R24 requires assistance with bed mobility, eating and hygiene and that she is frequently incontinent of urine and occasionally incontinent of bowel. 7. On 8/16/11 E6 stated that R26 refused to have another dressing change for observation purposes. On 8/18/11 E1, the administrator	F 314		

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F 314	Continued From page 21 stated that R26 was being admitted to the hospital due to respiratory problems. The record of R26 an 82 year old female admitted to the facility with diagnosis including Diabetes (co morbidities) was reviewed. R26's record contains a "Braden Scale for Predicting Pressure Sore Risk" dated 8/6/11 that scores her 15 which is considered "Mild Risk". R26's record contains a "Weekly Pressure Ulcer Assessment" dated 8/6/11 that states she developed a right inner buttock pressure sore measuring .8cm by 1 cm by .01 cm depth. R26's record contains an MDS dated 8/10/11 that states she requires extensive assistance for transfers, dressing and hygiene. This MDS also states that she requires assistance with bed mobility. This MDS also states that R26 is incontinent of bowel and bladder. 8. On 8/16/2011 at at 11:45 A.M., R8's skin condition was checked in the presence of E10 (CNA-certified nurse assistant). R8 has a stage II pressure ulcer on her right upper spine. Review of record "Monthly Skin Assessment" dated 8/8/2011 showed that R8's pressure ulcer measures 1.5 x 3x 0.1 cm. According to R8's record,this pressure ulcer was first identified and was acquired by R8 at the facility on 8/8/2011. Review of current care plan indicated that R8 was identified with at risk for pressure ulcers related to declining condition, incontinence of bladder and bowel, history of CVA(cerebral vascular accident), right sided weakness and loss sensation in feet. The care plan indicates that interventions to address R8's pressure ulcer includes for R8 to be placed on a pressure redistributing mattress in bed and wheelchair cushion.	F 314		

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F 314	Continued From page 22 R8 was observed on 8/15/2011 at around 10:30 A.M., 8/16/2011 at 12:30 P.M., and 2:30 P.M. R8 was sitting in a reclining wheelchair. Further observation showed that R8's was sitting directly on the reclining wheelchair without an pressure redistribution chair cushion. On 8/16/2011 at 2:30 P.M., E13 (CNA) stated that she never had seen R8 's reclining wheelchair cushion. On 8/16/2011 at 3:10 P.M. during the daily status meeting, the concern that R8 was without redistribution cushion in a reclining wheelchair was discussed with E1 (Administrator) and E2 (Director of Nursing) during the daily status meeting. On 8/17/2011 at 12:30 P.M., R8 was observed in the main dining room. R8 was sitting on a reclining chair. R8 was still without a pressure redistribution cushion. E5 (Assistant Director of Nursing) was present during this observation. In an interview on 8/16/11 at 2:30 PM with E1, the administrator and E2, the director of nursing, they stated that they are aware of the problem regarding pressure sores recently acquired in the facility. E1 stated that they are looking at the reasons why this occurred. E1 stated that in July 2011 the facility census went from 90 to over 100 and that the facility had to hire more staff to meet the needs of their residents. E1 stated that the care was not given as it should be regarding pressure sore prevention because they did not have enough staff. On 8/17/11 at 10:15 AM E1 stated that after looking at the staffing, they now believe that staffing was sufficient. E1 stated that the facility experienced power outages that utilized the back-up generator. E1 stated that the primary goal during these power outages was making sure the residents were hydrated. E1	F 314		

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F 314	Continued From page 23 stated that perhaps some preventive care was overlooked at this time. In an interview on 8/22/11 at 9:30 AM with Z1, the medical director, he states that he was aware of the facilities acquired pressure sores in the quarterly quality assurance meetings. Z1 states that he was probably informed of the increasing numbers of acquired pressures sore but he does not recall how many the facility has. Z1 states that he believes in the general philosophy of pressure sore prevention that includes skin checks, frequent repositioning and incontinence care. Z1 states that the facility needs to be vigilant in these preventive measures. Z1 states that there was a breakdown in these processes but he cannot say where the breakdown occurred. Z1 states that he was not involved in recommending interventions but that he did agree with the plan of removal regarding the immediate jeopardy situation.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow their Medication	F 322		9/20/11

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F 322	Continued From page 24 Administration /Naso-Gastric Tubes, Gastrostomy and Jejunostomy Tubes Policy and Procedure for one of four residents, (R1), with gastrostomy tubes, in the sample of twenty-one. Findings include: The undated Medication Administration /Naso-Gastric Tubes, Gastrostomy and Jejunostomy Tubes Policy and Procedure, provided 8-16-2011 at 10:20am., by E2, (DON/Director of Nursing) is, "Policy: Medication will be provided for residents requiring feeding through an artificial opening into the stomach or via naso-gastric tube. Procedure for administering medication: 2. Assist resident to semi-Fowler position unless contraindicated. 3. Expose tube, place basin under tube, and remove plug. Check patency of tube and for placement of tube prior to administering any solution. 7. Clamp the tube before it empties, and remove syringe. Rinse and insert plug." E2, (DON) on 8-16-2011 at 2:55pm. stated, "Semi-fowler position is forty-five degrees." On 8-16-2011 at 8:30am. R1 was in bed. The head of the bed was elevated fifteen degrees. E3, (LPN/Licensed Practical Nurse) did not increase bed elevation to forty-five degrees. E3, did not place a basin under R1's gastrostomy tube prior to removing the plug, nor during the medication administration. R1's gastrostomy tube patency and placement were not checked prior to administering R1's 9:00am. medication. R1's 9:00am. medication administration consisted of 5ml., (milliliters) of multivitamins, four crushed tablets, and 320ml. of water. E3, then clamped	F 322		

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F 322	Continued From page 25 the gastrostomy tube and did not rinse the syringe. E3, (LPN) on 8-16-2011 at 8:45am. stated, "No, I did not check placement of (R1's) gastrostomy tube, prior to administering her medication. I checked it, when I arrived this morning, on rounds."	F 322		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		9/20/11

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F 329	Continued From page 26 by: Based on observation, interview and record review the facility failed to complete an assessment to identify reasons for insomnia, and failed to try alternative interventions to treat insomnia, prior to initiating duplicate therapy hypnotic medications. The facility also failed to develop care plans for the hypnotic medications and for an antipsychotic medication. This is for 1 resident (R13) out of 13 reviewed for psychotropic medications in the total sample of 21. The findings include: R13 is an 88 year-old cognitively impaired resident who was admitted to the facility on 5/12/11 with diagnoses including Alzheimer's Disease and Psychotic Disorder, according to the admission Minimum Data Sets (MDS) dated 5/19/11. R13 has physician's order for Trazodone 50 mg every night (for insomnia), and Ambien 10 mg every night, according to the physician's order sheet (POS) dated August 2011. R13 received the Trazodone from 8/3/11 to current (8/17/11), and received Ambien on 7/30, 7/31, 8/12 - 8/17/11, according to the Medication Administration Record (MAR). There was no documentation of an assessment for R13's insomnia and no documentation of non-pharmacological interventions tried prior to giving R13 Trazodone and Ambien. This was confirmed by E7 (Nurse) on 8/18/11 at 10:45 AM. There is no care plan for the use of the antipsychotic and hypnotic medications according to review of the facility's care plan. This was confirmed by E8 (Care Plan Coordinator) on	F 329		

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F 329	Continued From page 27 8/18/11 at 11:00 AM. The facility does not have a policy for the use of hypnotic or antipsychotic medications. This was confirmed by E2 on 8/18/11 at 1:20 PM. On 8/17/11 R13 was asleep in a wheelchair in the 100 hallway at 10:30 AM and at 11:25 AM. On 8/18/11 R13 was asleep in bed at 10:35 AM, 10:47 AM and 11:15 AM.	F 329		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to ensure that residents were offered a bedtime snack. The findings include:	F 368		9/20/11

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F 368	Continued From page 28 On 8/17/11 at 10:00 AM five alert residents attending the group meeting. All 5 residents confirmed that the facility does not offer snacks at bedtime. All 5 residents said that they would like to be offered a snack at bedtime. On 8/18/11 at 11:00 AM E12 (Food Service Supervisor) stated that the kitchen staff prepares a cart for night time snacks and brings it to the utility room. E12 said that nursing staff are supposed to pass the snacks to residents. The facility's policy states that H.S. (night) snack will be provided daily and will be passed by the nursing staff.	F 368		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that the ice machine was cleaned regularly; failed to store clean dishes on a clean surface; failed to ensure that dishes and pans were clean prior to storing; failed to follow manufacturers instructions for	F 371		9/20/11

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sanitizing; failed to ensure that staff were properly trained in testing for sanitation concentration, and failed to ensure that the chemical concentration of the dish machine was at the appropriate level.

This failure has the potential to affect all 102 residents residing at the facility.

The findings include:

On 8/17/11 between 1:30 - 2:00 PM the following observations were made in the kitchen: The inside of the ice machine was soiled with a pink-orange substance and a smattering of black spots. On 8/17/11 at 12:21 PM, E9 (Cook) stated that the ice machine is cleaned by the maintenance department. A bin of bowls, identified as clean by E9, was in a plastic bin that was soiled; additionally the cloth covering the bowls were soiled. The lids covering 3 containers of dry cereal were soiled with dried spills and crumbs. Five utensil drawers were soiled with crumbs or crud, and the utensils were in contact with the soiled areas. One scooper was noted with a dried substance adhered to the inside. Two rubber head spatulas were in poor condition with missing chunks of rubber. Pans stored in the clean had visible grease on them. The cheese grater stored in the clean area had a dried substance adhered to the inside. Three shallow soup bowls stored in the clean area had dried food stuff adhered to them.

On 8/17/11 at 2:05 PM the sanitizing tub of the 3 compartment sink measured a temperature of 114 degrees Fahrenheit (F). The sign above the tub states that the temperature of the sanitizing tub should be 75 degrees F. The staff were not

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F 371	Continued From page 30 aware of this requirement. E11 (Dish Machine Operator) was asked to measure the sanitation concentration of the automatic dish machine. E11 used a quaternary ammonia (QT-40) strip to measure the chemical concentration. The strip turned a color that did not match the possible colors on the result ledger. E11 tried 2 more times and got the same result. The facility uses a low temperature, chlorine-based chemical solution to sanitize dishes in the dish machine. E11 was not aware that he was using the wrong test strip to measure the sanitation concentration. A chlorine test strip was then obtained and the concentration of the chlorine sanitizer measured 200 ppm. The facility's policy titled, "Warewashing - Dishmachine" dated 07/07 states that the chlorine sanitizing level should be 50 ppm. On 8/17/11 at 2:00 PM E1 (Administrator) toured the kitchen and viewed the above described concerns.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		9/20/11

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F 441	Continued From page 31 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow manufacturer's guidelines and their Cleaning and Disinfecting Blood Sugar Monitoring Devices Policy and Procedures, for seven residents, utilizing the same blood sugar monitoring device, (R2, R27, R28, R29, R30, R31, and 32). Findings include:	F 441		

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F 441	Continued From page 32 The August 2010, (Blood sugar monitoring device), Cleaning/Disinfecting Policy is, "Policy: (Blood sugar monitoring devices) will be cleaned/disinfected in accordance with the CDC, (Centers for Disease Control) recommended guidelines, to prevent the spread and transmission of blood borne pathogens. Procedure: Cleaning and disinfecting guidelines: To disinfect your monitor, clean the monitor and wipe down using a solution of 10% bleach. Alcohol is no longer recommended for disinfecting of meters. Disinfecting must be completed between each resident use, wearing gloves to avoid transmission of blood borne pathogens." Blood sugar monitoring device, Chapter 8, page 41, "Caring for your monitor, Cleaning Your Monitor, Healthcare professionals; acceptable cleaning solutions include 10% bleach, 70%alcohol, or 10% ammonia." On 8-16-2011 at 11:14am., E4, (RN/Registered Nurse) checked R32's blood sugar with the blood sugar monitoring device. E4, then used an antimicrobial alcohol gel hand wipe to disinfect/clean the blood sugar monitoring device. E4, (RN) on 8-16-2011 at 11:35am. stated, "I think the (Name Brand, antimicrobial alcohol gel wipes) are what we've been using to clean the (blood sugar monitoring devices). I've been using it. There is one (blood sugar monitoring device) for each wing of the facility, for residents residing on that wing. We do not have individual resident (blood sugar monitoring devices)." The antimicrobial alcohol gel wipes active	F 441		

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F 441	Continued From page 33 ingredients, identified on the container, are, "Alcohol 65%." On 8-16-2011 at 11:40am., E2, (DON/Director of Nursing) stated, "We use (Name Brand) to clean (blood sugar monitoring devices)." E2 then provided the container. The container identified the active ingredients as, "1:10 parts bleach, and 6500 parts per million sodium hypochlorite." (As Manufacturer recommended for cleaning/disinfecting the blood sugar monitoring device). E3, (ADON/Assistant Director of Nursing) on 8-16-2011 at 11:55am., stated, "E4, (RN) works full time. There are seven residents, (R2, R27, R28, R29, R30, R31, and R32), that would use the (Blood sugar monitoring device) that (E4/RN) used, and cleaned with the hand gel. All seven residents have their blood sugar checked." On 8-16-2011 at 2:55pm. E2, (DON) stated, "I did a 3-29-2011 staffing and discussed cleaning of (blood sugar monitoring devices). (R4/RN) was present at this in-service. Our Policy is to clean with the 1:10 parts bleach solution."	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by	F9999		

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F9999	Continued From page 34 the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by the following:	F9999		

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F9999	Continued From page 35 Based on interview and record review the facility failed/neglected to follow and implement the facility's policy and procedure for "Pressure Ulcer Prevention" in the following areas; 1. Assessment; - A standardized pressure ulcer risk assessment (Braden Scale) will be used to identify residents who are at risk for the development of pressure ulcers. This assessment will be completed upon admission, weekly x 4 weeks, quarterly and when a significant change in the resident's condition is noted. 2. Planning: - An individual plan of prevention will be developed to meet the needs of the resident. It will include the consideration of mechanical support surfaces, nutrition, hydration, positioning, mobility, continence, skin condition and overall clinical condition of the resident as well as the risk factors as they apply to each individual. 3. Implementation: - Interventions for the prevention of pressure ulcers will be individualized to meet the specific needs of the resident. Interventions will consider the assessment of risk and skin condition of the resident. 4. Evaluation and Reassessment: - The facility's Care Management System committee will review program components to evaluate the effectiveness of the prevention program and facility systems. Findings and recommendations will be reviewed with the QA Clinical Committee. Based on evaluation, the need for reassessment and further changes to the individual resident' plan of care will be determined and acted upon. This is for 5 (R4, R5, R6, R8, R14) of the 7 residents sampled for pressure sores in a total sample of 21 with 3 residents (R24, R25 and	F9999		

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F9999	Continued From page 36 R26) in the supplemental sample. These failures contributed to the development and worsening of avoidable facility acquired pressure sores in various stages for these 8 residents. Findings include; A review of the facility's "Resident Census and Conditions of Residents" under section "D" Skin Integrity noted that the facility reported 13 residents with pressure sores and only 2 of these residents had pressure sores on admission. In an interview on 8/16/11 at 2:30 PM with E1, the administrator and E2, the director of nursing, they stated that they are aware of the problem regarding pressure sores recently acquired in the facility. E1 stated that they are looking at the reasons why this occurred. E1 stated that in July 2011 the facility census went from 90 to over 100 and that the facility had to hire more staff to meet the needs of their residents. E1 stated that the care was not given as it should be regarding pressure sore prevention because they did not have enough staff. On 8/17/11 at 10:15 AM E1 stated that after looking at the staffing, they now believe that staffing was sufficient. E1 stated that the facility experienced power outages that utilized the back-up generator. E1 stated that the primary goal during these power outages was making sure the residents were hydrated. E1 stated that perhaps some preventive care was overlooked at this time. In an interview on 8/22/11 at 9:30 AM with Z1, the medical director, he states that he was aware of	F9999		

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the facilities acquired pressure sores in the quarterly quality assurance meetings. Z1 states that he was probably informed of the increasing numbers of acquired pressures sore but he does not recall how many the facility has. Z1 states that he believes in the general philosophy of pressure sore prevention that includes skin checks, frequent repositioning and incontinence care. Z1 states that the facility needs to be vigilant in these preventive measures. Z1 states that there was a breakdown in these processes but he cannot say where the breakdown occurred. Z1 states that he was not involved in recommending interventions but that he did agree with the plan of removal regarding the immediate jeopardy situation.

1. On 8/16/11 at 10:10 AM R5 was in bed waiting for her dressing change. E6, the wound care nurse, removed R5 ' s coccyx dressing. R5 ' s wound is a Stage 3 pressure ulcer measuring 2.1 centimeter (cm) by 1.3cm by .2cm depth. The pressure sore has a thin center yellow slough approximately 25%. These measurements confirms a worsening of the pressure sore.

The record of R5, a 78 year old female admitted to the facility on 8/15/09 with diagnoses (co morbidities) including Diabetes, Coronary Artery Disease, Hypertension and Anxiety was reviewed. R5 ' s record contains a physician ' s treatment order dated 7/18/11 that states. " Cleanse coccyx with sterile normal saline apply Maxorb AG and a 4 by 4 Exuderm every 3 days and as needed until resolved. " R5 ' s record contains a " Braden " pressure sore scale dated 6/13/11 that states she scored a 15 which is considered " mild risk " The minimum data set dated 5/17/11

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states that she needs extensive assistance to transfer, assistance to position herself in bed, and uses a wheelchair for ambulation and is incontinent of bowel and bladder. R5's "Weekly Pressure Ulcer Assessment" sheet dated 7/18/11 that states this is the date that a stage 2 coccyx pressure sore was identified and measured .52 cm by .51cm. R5's "Weekly Pressure Ulcer Assessment" dated 7/26/11 states that the wound is now 1.5cm by 1.5cm by .1 depth which is a worsening of the pressure sore. R5's "Weekly Pressure Ulcer Assessment" sheet dated 8/2/11 states that her pressure sore is a stage 3 measuring 1.5cm by .8cm by .2cm with 50% necrotic tissue, this is a significant worsening of the pressure sore.
R5's "Weekly Pressure Ulcer Assessment" sheets show a decline or worsening in the pressure sore every week. The physician's order sheet do not show a change in treatment since the onset of the pressure sore on 7/18/11.
R5's record lacks a comprehensive plan of care to prevent and treat pressure ulcers.

In an interview with E6, the wound care nurse, she states that some physician's utilize a wound care clinic and some do not. E6 stated that some physician's are open to treatment suggestions and some are not. E6 stated she does not remember which residents have physician's that will use a wound clinic. E6 stated that she is aware that the wound is worse than it was previously.

2. On 8/16/11 at 10:20 AM R14 was in bed waiting for her heel dressing to be changed. R14 has an unstageable pressure ulcer to her left heel measuring 4.0cm by 5.0 cm by .1 cm at the

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CRYSTAL PINES REHAB & HCC	335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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periphery of the wound. R14's wound has a black eschar center (75%) with surrounding red tissue. This is a worsening of the "suspected deep tissue injury" that was documented on 8/9/11.

The record of R14,an 87 year old female admitted to the facility on 6/20/11 with diagnoses (co morbilities) including Pelvic Fracture, Hypertension, Weakness and Difficulty in walking, was reviewed. R14's record contains a "Braden Scale for Predicting Pressure Sore Risk" dated 7/11/11 that states she scored a 22 which is "mild risk" on this scale. R14's record contains a "Weekly Pressure Ulcer Assessment' dated 8/5/11 that states a suspected deep tissue injury was found and measured 5.2cm by 5.9cm and depth is stated as "blister". R14's record contains a physician's order for treatment dated 8/8/11 that states "Cleanse left medial heel with normal saline. Apply skin prep to intact blister, cover with optifoam and wrap with kerlix." R14's record contains a Minimum Data Set (MDS) dated 6/20/11 that states she needs assistance with bed mobility, transfers dressing and hygrine. R14's MDS states that she uses a wheelchair for ambulation and she continent of bowel and bladder.
In an interview with E6,the wound care nurse, she stated that she does not know how this resident developed her pressure sore and that her assessments states she was at low risk for development of pressure sores.

3. On 8/16/11 at 10:00 AM E6 stated that R4 was admitted to the hospital last night due to her pressure sores. E2, the director of nursing, presented a history and physician report from the hospital regarding R4. This report states "...She

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F9999	Continued From page 40 is here from the nursing home with chief complaint of right foot pain and right foot drainage...Family also noted that the patient also had decubitus ulcers for some time but noted increased wound care needs for the past month...2 unstageable ulcers on the patient's right foot, foul smelling with necrotic tissue present. Also deep tissue injury in the medial right knee and decubitus on the right hip...Will be consulting surgery for wound debridement and care..." The record of R4's record contains an 84 year old female admitted to the facility in June of 2010 with diagnoses (co morbidity) including Diabetes, Dementia, Anxiety Hypertension and Joint disease was reviewed. R4's MDS dated 5/26/11 states that she requires assistance with turning in bed, transferring, dressing and bathing. R4's MDS also states that she is frequently incontinent of both bowel and bladder and that she uses a wheelchair for ambulation. E4's record contains a "Braden scale for predicting pressure sore risk" dated 7/6/11 that states a score of 10 that signifies "high risk" for pressure sores. R4's record contains "Weekly Pressure Ulcer Assessment" dated 6/16/11 that states this date is when a stage 3 right hip pressure ulcer was identified and measured 3cm by 1.8cm by .2cm with 60% necrotic tissue. R4's record contains a "Weekly Pressure Ulcer Assessment" dated 8/6/11 that states a stage 2 left medial knee pressure ulcer was noted measuring 3cm by 2cm by .2cm depth. R4's record contains a "Weekly Pressure Ulcer " dated 8/9/11 that states the left medial knee pressure sore is now a stage 3 with 75% necrotic tissue.	F9999		

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4. On 8/16/11 at 11:00 AM R25 was in bed waiting for her dressing change. E6 measured the right buttock wound at .3cm by .2cm by .1 cm depth and a Stage 2 pressure ulcer. The wound was bleeding slightly.
E6 stated that she does not know why R25 developed this pressure ulcer.

The record of R25 a 94 year old female admitted to he facility with diagnoses (co morbidities) including Urinary Incontinence, Depression and Hypertension was reviewed. R25's record contains a "Braden Scale for Predicting Pressure Sores" that state she scored an 11 on 7/24/11 which is considered "High Risk" R25's record contains a "Weekly Pressure Ulcer Assessment" dated 8/2/11 that states she acquired a left buttocks stage 2 pressure ulcer measuring .5cm by .8cm by .1 cm depth. R25's record contains an MDS dated 7/21/11 that states she required extensive assistance to transfer and toilet and some assistance for bed mobility and dressing. This MDS states R25 used a wheelchair for ambulation and that she is incontinent of uri ne and occasionally incontinent of bowel.

5. On 8/16/11 at 10:30 AM R6 was in bed waiting for her dressing change. E6 measured her right hip Stage 2 pressure sore as .5cm by .5cm and her thoracic spine Stage 2 pressure sore as .8cm by .7cm by .1 cm depth. E6 states that she does not know why this resident developed her pressure sores.

The record of R6 a 93 year old female admitted tot he facility with diagnoses(co morbidities) including Congestive Heart Failure, Late Effect

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Cerebral Vascular Accident and Muscle Weakness was reviewed. R6's record contains a "Weekly Pressure Ulcer Assessment" dated 6/4/11 that states she acquired a thoracic spine Stage 2 pressure sore measuring .3cm by .3cm by .1cm. R6's record contains a "Weekly Pressure Ulcer Assessment" dated/12/11 that states she acquired a right hip pressure sore measuring 1.3cm by .2cm. R6's record contains an MDS dated 6/5/11 that states she required extensive assistance with transfers, dressing and hygiene. This MDS also states that she is incontinent of bowel and bladder.

6. On 8/16/11 at 11:50 AM R24 was in bed waiting for her dressing change. E6 measured her left buttock Stage 2 pressure sore 1cm by .5cm by .1 cm depth. This wound was bleeding slightly. E6 stated that she does not know why R24 developed a pressure ulcer.

The record of R24 an 88 year old female admitted to the facility with diagnoses (co morbidities) including Dysphagia, Atrial Fibrillation, Ischemic Heart Disease and Dementia was reviewed. R24's record contains a "Braden Scale for Predicting Pressure Sore Risk" dated 8/5/11 that scores her a 15 which is considered "Mild Risk". R24's record contains a "Weekly Pressure Ulcer Assessment" dated 8/5/11 that states her right inner buttock Stage 2 pressure ulcer measured 1.6cm by .6cm by .001 cm depth. R24;s record contains a MDS dated 7/5/11 that states she requires extensive assistance to transfer and for dressing. This MDS also states that R24 requires assistance with bed mobility, eating and hygiene and that she is frequently incontinent of urine and occasionally

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F9999	Continued From page 43 incontinent of bowel. 7. On 8/16/11 E6 stated that R26 refused to have another dressing change for observation purposes. On 8/18/11 E1, the administrator stated that R26 was being admitted to the hospital due to respiratory problems. The record of R26 an 82 year old female admitted to the facility with diagnosis including Diabetes (co morbidities) was reviewed. R26's record contains a "Braden Scale for Predicting Pressure Sore Risk" dated 8/6/11 that scores her 15 which is considered "Mild Risk". R26's record contains a "Weekly Pressure Ulcer Assessment" dated 8/6/11 that states she developed a right inner buttock pressure sore measuring .8cm by 1 cm by .01 cm depth. R26's record contains an MDS dated 8/10/11 that states she requires extensive assistance for transfers, dressing and hygiene. This MDS also states that she requires assistance with bed mobility. This MDS also states that R26 is incontinent of bowel and bladder. 8. On 8/16/2011 at at 11:45 A.M., R8's skin condition was checked in the presence of E10 (CNA-certified nurse assistant). R8 has a stage II pressure ulcer on her right upper spine. Review of record "Monthly Skin Assessment" dated 8/8/2011 showed that R8's pressure ulcer measures 1.5 x 3x 0.1 cm. According to R8's record,this pressure ulcer was first identified and was acquired by R8 at the facility on 8/8/2011. Review of current care plan indicated that R8 was identified with at risk for pressure ulcers	F9999		

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F9999	Continued From page 44 related to declining condition, incontinence of bladder and bowel, history of CVA(cerebral vascular accident), right sided weakness and loss sensation in feet. The care plan indicates that interventions to address R8's pressure ulcer includes for R8 to be placed on a pressure redistributing mattress in bed and wheelchair cushion. R8 was observed on 8/15/2011 at around 10:30 A.M., 8/16/2011 at 12:30 P.M., and 2:30 P.M. R8 was sitting in a reclining wheelchair. Further observation showed that R8 was sitting directly on the reclining wheelchair without a pressure redistribution chair cushion. On 8/16/2011 at 2:30 P.M., E13 (CNA) stated that she never had seen R8 's reclining wheelchair cushion. On 8/16/2011 at 3:10 P.M. during the daily status meeting, the concern that R8 was without redistribution cushion in a reclining wheelchair was discussed with E1 (Administrator) and E2 (Director of Nursing). On 8/17/2011 at 12:30 P.M., R8 was observed in the main dining room. R8 was sitting on a reclining chair. R8 was still without a pressure redistribution cushion. E5 (Assistant Director of Nursing) was present during this observation. All of the documentation presented by the facility was reviewed. B	F9999		